SESSIONS PLASTIC SURGERY CENTRE

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Occupation: _____ Activity level at work (1-10, 10 highest) _____

Emergency Contact: _____ Relationship: _____

Phone Number(s) he/she can be reached at: _____

How did you hear about us? _____

Reasons for Appointment: _____

Your Primary Care Doctor: _____ Phone: _____

Address: _____

Pharmacy Name: _____ Phone: _____

Address: _____

MEDICAL PROBLEMS OR CONDITIONS NOW UNDER TREATMENT BY A PHYSICIAN:

_____

_____

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE:

Medication/Supplement	Purpose of Medication	Dosage Amount	Take How Often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES:

_____

Do you drink? YES NO If yes, how often: RARE OCCASIONALLY DAILY

Do you smoke? YES NO If yes, how often: RARE OCCASIONALLY DAILY

Do you use recreational drugs? YES NO If yes, how often: RARE OCCASIONALLY DAILY

Have you ever experienced difficulties with General Anesthetic Agents/Anesthesia? YES NO

If YES, please explain: _____

SURGERIES (OPERATIONS & COSMETIC SURGERIES) OR PROCEDURE:

Type	Date	Complications or Difficulties
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had any of the following:

Asthma	YES NO	Heart Attack	YES NO	Diagnosed Arthritis	YES NO
Bronchitis	YES NO	Heart Murmur	YES NO	Shortness of Breath	YES NO
Cough	YES NO	Stomach Ulcer	YES NO	Low Blood Pressure	YES NO
Cirrhosis	YES NO	Sickle Cell	YES NO	Collagen Disease	YES NO
Dizziness	YES NO	Thyroid Disease	YES NO	Chest Pain/Angina	YES NO
Stroke	YES NO	Tuberculosis	YES NO	Gallbladder Disease	YES NO
Hepatitis	YES NO	Seizures	YES NO	Aching/Swelling of Joints	YES NO
Emphysema	YES NO	Abnormal Rhythm	YES NO	Circulatory Problems	YES NO
Palpitations	YES NO	Anemia	YES NO	Urinary Tract Infection	YES NO
Diabetes	YES NO				

Are you currently experiencing any problems with back pain? YES NO

If YES, please explain: _____

Have you had or currently have any other disease or medical issues? YES NO

If YES, please explain: _____

Have you ever been exposed to any of the following:

Intravenous Drugs	YES NO	Hepatitis	YES NO	HIV	YES NO
Infectious Diseases	YES NO	Liver Transplant	YES NO	Tuberculosis	YES NO
Blood Transfusion	YES NO	AIDS	YES NO		

Are you currently pregnant? YES NO

Do you anticipate a pregnancy within the next year? YES NO

Have you ever had children? YES NO **If YES, please list previous pregnancies below:**

Year _____ Vaginal Birth or C-Section

Year _____ Vaginal Birth or C-Section

Year _____ Vaginal Birth or C-Section

Year _____ Vaginal Birth or C-Section

Year _____ Vaginal Birth or C-Section

Year _____ Vaginal Birth or C-Section

HIPPA

You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you can ask that we contact you at home rather than at work. We will accommodate reasonable requests. By selecting "YES" below, you give us your permission to leave you messages.

You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends.

Please note some procedures require medical clearance from your primary physician. By providing us with your primary physician's information, you give us permission to request medical clearance if required by doctor. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy simply, contact our front desk receptionist.

I, _____ (**PRINT NAME**) hereby request the use of the following confidential channels for the communication of the information related to my personal health or treatment. This request supersedes any prior request for confidential channel communications I have made.

Cell Phone	YES NO	Fax	YES NO
Home Phone	YES NO	E-Mail	YES NO
Work Telephone	YES NO	Other _____	YES NO

Fax Medical Records to Primary Care Physician if needed YES NO

Any other Channel of Communication: _____

Please list Name of Authorized people (i.e. spouse, parent, sibling, finance, etc.) that you are allowing us to discuss pertinent information with:

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

I hereby acknowledge that I have been presented with a copy of SESSIONS PLASTIC SURGERY CENTRE of Privacy Practices. I have read, understand and accept the above policies.

Print Name: _____ Date: _____

Signature: _____ (Legal Guardian's Signature if minor or disabled)